Employee Benefits Corporation

My Personal Information:

Participant Name | Middle Initial | Last Name

Mailing Address | City | State | Zip

Company Name | E-mail Address (We do not share your e-mail address) | Social Security Number

Authorize Individuals to Receive Protected Health Information

I _____ (name) am a participant in a plan sponsored by my employer. I understand that my employer has engaged Employee Benefits Corporation to provide administrative services to the plan. I hereby authorize Employee Benefits Corporation to use or disclose, with the person(s) listed below, my protected health information (PHI) regarding claims submission and reimbursement, eligibility for the plan, enrollment and disenrollment, or other information related to the plan(s) checked below.

Plan type(s) for which PHI may be released (check all that apply):

☐ BESTflex℠ Plan ☐ EBC HRA℠ ☐ COBRASecure℠

Participant Authorization Form

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Person(s) authorized to receive PHI and their relationship:

Name | Relationship

Name | Relationship

For Employee Benefits Corporation Use Only

Group ID Number

Specialist

Processed Date

Authorization expiration (check one)

○ Authorization will expire when I am no longer a participant in the plan or my employer terminates the plan

○ From: _____ to: _____ ○ _____

Beginning and End Dates (mm/dd/yyyy to mm/dd/yyyy) | Date (mm/dd/yyyy)

Authorized information (check one)

○ Any information related to the plan(s)

○ Only: _____

(Specify the type of information that may be disclosed)

Participant Certification: I may revoke this authorization at any time prior to its expiration date by notifying Employee Benefits Corporation in writing, but revocation will not affect any actions Employee Benefits Corporation took before the revocation was received. I may see and copy the information requested on this form if I ask for it. I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment). The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving person. Employee Benefits Corporation is not responsible for what the receiving person does with the information.

X _____ / / _____

Signature | Date (mm/dd/yyyy)

Web Address:
www.ebcflex.com

U.S. Mail:
Employee Benefits Corporation
PO Box 44347
Madison WI 53744-4347

Phone:
Monday - Friday, 8:00 - 5:00 CST
608 831 8445
800 346 2126

Fax:
608 831 4790

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